Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

April 18, 2011

Mr. Neville Wise, Acting Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 E. Main Street, 6W-A
Frankfort, KY 40621

Re: Kentucky Title XIX State Plan Amendment, KY 10-005

Dear Mr. Wise:

We have reviewed Kentucky State Plan Amendment (SPA) KY 10-005, which was submitted to the Atlanta Regional Office on July 29, 2010. This amendment enhances and changes the delivery system of the State's lock-in program with the newly formed high utilization PCCM.

Based on the information provided, we are now ready to approve Kentucky SPA 10-005 as of April 15, 2010. The effective date is July 1, 2010. The signed CMS-179 and the approved plan pages are enclosed. If you have any questions regarding this amendment, please contact Maria Drake at (404) 562-3697 or Ed Smith at (502) 223-5927.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10-005

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFS 431.54(e)

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 - ($1.0 Million)
b. FFY 2011 - ($3.5 Million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Page 7.2.1(a)
Attachment 3.1-B, Page 22
Attachment 3.1-A, Page 7.5.2
Attachment 3.1-B, Page 31.1
Attachment 4.19-B, Page 20.4
Attachment 3.1-A, Page 7.1.1(a)
Attachment 3.1-B, Page 13.2
Attachment 4.19-B, Page 20.12(f)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT
This State Plan Amendment will prevent Medicaid recipients from refilling a prescription until 90% of the prior fill has been utilized. However, in the case of an emergency, recipients may obtain a refill earlier if the prescribing physician or pharmacy submits a prior authorization.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Elizabeth A. Johnson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: July 26, 2010

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 04/15/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/10

20. SIGNATURE OF REGIONAL OFFICIAL: Jackie Glaze

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

Approved with following changes as authorized by State Agency on email dated 03/15/11:

Block # 8 **Changed to read**: Attachment 3.1-A, page 7.1.1(a), attachment 3.1-A page 7.2.1(a), Attachment 3.1-A page 7.2.1(a)(o), Attachment 3.1-F (Lock-in program) pages 1 thru 14 new and Attachment 3.1-F (KenPac) pages 1 thru 15.

FORM HCFA-179 (07-92)

E. The cost of preparations used in injections is not considered a covered benefit, except for the following:

(1) The Rhogarn injection.
(2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
(3) Depo Provera provided in the physician office setting.
(4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
(5) Long acting injectable risperidone.
(6) An injectable, infused or inhaled drug or biological that is:
    a. Not typically self-administered;
    b. Not listed as a noncovered immunization or vaccine; and
    c. Requires special handling, storage, shipping, dosing or administration.

F. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.

G. Telephone contact between a physician and patient is not a covered service.

H. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:

(1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
(2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

(g) Excision: barthotin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
(h) Extraction: foreign body, and teeth (per existing policy).
(i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
(j) Hymenotomy.
(k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
(1) Meatotomy/ urethral dilation, removal calculus and drainage of bladder without incision.
(m) Myringotomy with or without tubes, otoplasty.
(n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, otoscopy, and sigmoidoscopy or proctosidmoidoscopy.
(o) Removal: IUD, and fingernail or toenails.
(p) Tenotomy hand or foot.
(q) Vasectomy.
(r) Z-plasty for relaxation of scar/contracture.

d. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

2 Outpatient Hospital Services

a. Hospital outpatient services are limited to therapeutic and diagnostic services as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration).

b. For recipients in the Lock-In Program, non-emergency services will be covered only in the recipients designated Lock-In hospital.

c. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

J. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

K. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.

L. Epidural injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.

M. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary, subject to prior authorization requirements described in material on file in the state agency.

N. Coverage for an evaluation and assessment service, provided by a physician or physician assistant with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per year.

1. The evaluation and assessment service shall be:
   a. Performed face-to-face with the recipient;
   b. Be performed over a period of at least thirty (30) minutes.

2. The evaluation and assessment service shall include:
   a. Asking the recipient about tobacco use;
   b. Advising the recipient to quit using tobacco;
   c. Assessing the recipient's readiness to quit using tobacco products
   d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
   e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
   f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Kentucky enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

The State enrolls Medicaid beneficiaries into PCCMs. The PCCM receives a monthly case management fee of $4.00 per member per month. Services are paid on a fee-for-service basis.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
__X__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

Citation	Condition or Requirement

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i. fee for service;
____ii. capitation;
_X_iii. a case management fee;
____iv. a bonus/incentive payment;
____v. a supplemental payment, or
____vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

Not applicable

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

____vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

Citation	Condition or Requirement

The PCCM program, Kentucky Patient Access and Care System (KenPAC) was initially implemented by the state as a 1915 (b) waiver in 1985. By the time that the state implemented the program under 1932 authority, it was a mature PCCM model that required only minimal changes to be compliant with the requirements of the Balanced Budget Act.

The State began planning in 2000 to enroll the SSI population into KenPAC. Meetings were held with various advocacy groups and community agency representatives. Relationships were formed to assist the State in its outreach and education efforts. Additionally, forums were held across the State to allow for questions from recipients, advocacy groups, and other community agencies. Notifications were sent to recipients in January 2001 and a Help Desk was established within the agency. Enrollment was phased in over several months.
Ongoing participation is assured through regular meetings of the Physician Technical Advisory Committee. A toll-free telephone line is available for public and recipient questions and complaints.

1932(a)(1)(A)

5. The state plan program will ___/will not _X__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory__X___/ voluntary_____ enrollment will be implemented in the following county/area(s):

The Lock In program will be in all counties of the state except the current 16 counties covered through Passport. Passport (PHP) does their own Lock-In Program and oversees their locked in population/members for the 16 counties in the greater Louisville area

i. county/counties (mandatory) _____

ii. county/counties (voluntary)_____

ii. area/areas (mandatory)_____

iii. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ___The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

Citation	Condition or Requirement
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. _X_ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. _X_ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. _X_ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as 1905(a)(4)(C) defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. _X_ The state assures that all the applicable requirements 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. _X_ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. _X_ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 74.40	8. _X_ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. *Enrollment in KenPAC is limited to AFDC related recipients, Family Related Medicaid recipients, Poverty Related Women and Children, Kentucky Children's Health Insurance Program (KCHIP), SSI recipients age nineteen or above, SSI related Medicaid recipients and State Supplementation recipients.* 2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Citation	Condition or Requirement
	The following populations are exempt from enrollment in KenPAC: Individuals who meet the eligibility requirements for receipt of both Medicaid and Medicare (dual eligibles); American Indians who are registered members of a Federally recognized tribe; Children under 19 years of age who are eligible for SSI under Title XVI, described in section 1902(e)(3) of Title XIX of the Social Security Act, receiving foster care or adoption assistance under part E of Title IV, receiving foster care or otherwise in an out-of-home placement, in the custody of the Department of Juvenile Justice and placed outside of the home, or receiving services through a family- centered, community based coordinated care system receiving grant funds under 42 USC 501(a)(1)(D). Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. *Not applicable*
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ____Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients, who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ____Indianswho are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Citation	Condition or Requirement
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ____Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients, who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ____Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
	E. <u>Identification of Mandatory Exempt Groups</u>
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* *Children receiving services through a family-centered, community-based, coordinated care system receiving grant funds under 42 USC 501(a)(1)(D) are children receiving comprehensive services including case management through the Commission for Children with Special Health Care Needs of the Cabinet for Health Services.*

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: ____i. program participation, ____ii. special health care needs, or ____iii. both The state plan identifies these children in terms of program participation. (See definition in Number 1 above)

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_X___i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

As many children as possible will be identified through the Medicaid Management Information System (MMIS) through Aid Category. Others receiving comprehensive services will be identified by the Commission for Children with Special Health Care Needs. (This is applicable to items I – iv below)

i. Children under 19 years of age who are eligible for SSI under title XVI;

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* *If either the Commission for Children with Special Health Care Needs or a child's parent identifies that the child is enrolled in KenPAC, they may contact the Department and the Department will immediately disenroll the child from KenPAC with the appropriate exclusion code. Services provided to such children will not require authorization. Providers will be given emergency authorizations for claims processing until the child can be disenrolled.*
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. *The state utilized a Medicaid Management Information System (MMIS) to identify these recipients. They are identified in the system by a specific code.* ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. *The state utilized a Medicaid Management Information System (MMIS) to identify these recipients. They are identified in the system by a specific code.*

Citation		Condition or Requirement
42 CFR 438.50	F.	List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment Recipients are not enrolled in KenPAC if they participate in the Kentucky Health Insurance Premium Payment Program (KHIPP); are residing in a nursing facility; are residing in an intermediate care facility for the mentally retarded and developmentally disabled, are residing in a psychiatric hospital or psychiatric residential treatment facility; are a Hospice recipient; are enrolled in another managed care program; have an eligibility period that is only retroactive; are eligible as medically needy (spenddown); are in Administrative Hearing Status Related to KenPAC; are a Lock-In recipient; are Home and Community Based Waiver recipients; are Qualified Medicare Beneficiaries (QMB); are Qualified Disabled Working Individuals (QDWI); are Specified Low-income Medicare Beneficiaries (SLMB); are aliens who are approved for time-limited Medicaid due to an emergency medical condition; are receiving care coordination through the Hemophilia Treatment Program of the Kentucky Commission for Children with Special Health Care Needs; or are recipients for whom the primary payer is a third party payer other than Medicaid and whose health care is coordinated by a primary care provider.
42 CFR 438.50	G.	List all other eligible groups who will be permitted to enroll on a voluntary basis *This is not applicable since Kentucky does not have voluntary enrollment.*
	H.	Enrollment process.
1932(a)(4) 42 CFR 438.50	1.	Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: *The State assures that default enrollment will be based upon maintaining prior provider-patient relationships whenever possible. The mandatory assignment process uses an algorithm, which considers the age, sex, place of residence, PCP availability, and equitable PCP distribution. The recipient will be notified of his or her assignment to a PCP. (Applicable to i, ii, and iii below)* i. the existing provider-recipient relationship (as defined in H.1.i). ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: i. The state will __X__/will not ____ use a lock-in for managed care managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be ten (10) days. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* *Recipients are notified in writing of their auto assignment to a PCP, stating the reason for the auto assignment.* iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* *If recipient is auto-assigned upon initial enrollment, the notice notifying the recipient of auto assignment contain this information* v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* *The department generates a systems report that identifies KenPAC members not assigned to a primary care physician. Information contained in the report is transferred to the department's fiscal agent who forwards this information to Medicaid. It is then entered into two systems, one for non-SSI recipients and one for SSI recipients, and tested for accuracy. Member letters for PCP selection are then generated and mailed to the unassigned members requesting they select a primary care provider. After 10 business days, the system identifies recipients who have not selected a provider and auto assigns them to a PCP utilizing provider use over the past 18 months, gender, age, and medical service area.*

Citation	Condition or Requirement

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

A monthly report is generated from the Eligibility System that will be used by the Department to monitor changes in default assignments

1932(a)(4)
42 CFR 438.50

l. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. _X_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _____ This provision is not applicable to this 1932 State Plan Amendment.

4. _X_ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _____ This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement

5. _X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _X_/will not___ use lock-in for managed care.

2. The lock-in will apply for _12_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

__X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

The recipient may request disenrollment with cause if the recipient was homeless or a migrant worker at the time of enrollment and was enrolled by default.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

__X___ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

KenPAC recipients are free to seek the following services without prior authorization from the PCP:

1. Dental;
2. Mental Health;
3. Community Mental Health Centers;
4. Psychiatric Residential Treatment Centers;
5. Ophthalmology;

Citation	Condition or Requirement

6. Optometry;
7. Maternity Care;
8. Podiatry;
9. General Transportation;
10. Emergency Transportation;
11. Non-emergency Transportation;
12. EPSDT;
13. Kentucky Early Intervention Program;
14. Audiology;
15. Family Planning;
16. Local Health Department Preventive Services Program:
17. Chiropractic;
18. Newborn Care;
19. Specialized Childrens Service Clinic;
20. Health Access Nurturing Development Service:
21. School-based Services;
22. Emergency Services;
23. Urgent care; and
24. Departmental exemptions on case-by-case basis.

Citation		Condition or Requirement
1932 (a)(1)(A)(ii)	M.	Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

Not applicable

1. The state will_____/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. ____ The selective contracting provision in not applicable to this state plan.

Holly, Mary V. (CMS/CMCHO)

From: Holly, Mary V. (CMS/CMCHO)
Sent: Monday, April 18, 2011 12:05 PM
To: 'Wright, Wanda'; CMS SPA
Cc: Drake, Maria (CMS/CMCHO); FRIX, TERRY (CMS/SC); SANFORD, DICKY L. (CMS/SC)
Subject: Correction to form 179
Attachments: AL Approved 10-015 Attach 4 18-A page 2 - March 2011.doc; AL-10-015, Approval Letter, 179 and Plan Pages.pdf; AL Approved 10-015 Attach 4 18-A page 1 - March 2011.doc

Correction to the form 179 block 18 approval date is 04-12-11 vs 02-18-11. (see attached)

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Kentucky enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

A recipient, who has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, will be restricted to one or more of the following:

(1) One (1) primary care provider who:
- *a. Shall be accessible to the recipient within normal time and distance standards for the community in which the recipient resides;*
- *b. Shall provide services and manage the lock-in recipient's necessary health care services;*
- *c. If the lock-in recipient needs a specialty service that the designated primary care provider is unable to provide, the designated primary care provider shall refer the lock-in recipient to other providers as necessary so the recipient receives all medical necessary services.*
- *d. Shall participate in the recipient's periodic utilization review*
- *e. If the designated primary care provider is a physician, he may also serve as the lock-in recipient's designated controlled substance prescriber; or*

(2) One (1) prescriber for non emergency prescriptions for controlled substances. This provider shall serve as the sole prescriber and manager of controlled substances for the lock-in recipient.

For B.1 and B.2, place a check mark on any or all that apply.

Citation	Condition or Requirement
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	1. The State will contract with an ____ i. MCO __X_ ii. PCCM (including capitated PCCMs that qualify as PAHPs) ____ iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be: ____i. fee for service; ____ii. capitation; _X__iii. a case management fee; ____iv. a bonus/incentive payment; ____v. a supplemental payment, or ____vi. other. (Please provide a description below).
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. *Not applicable* If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

Citation	Condition or Requirement
	X vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* *In order to implement this program, the State had to file an Administrative Regulation with the Legislative Research Commission. As a result, a Public Hearing was conducted allowing the public to testify in support of or in opposition of this new program.* *The state also published Public Notices in the states three largest newspapers outlining this program.* *In addition, letters were sent to all providers and hospitals prior to implementation. The state also sent a letter to all current Lock-In participants explaining the new program.* *The state will continue to work with providers, legislators, advocates and recipients as this program is implemented through provider education meetings and letters.*
1932(a)(1)(A)	5. The state plan program will ___/will not X implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory X / voluntary_____ enrollment will be implemented in the following county/area(s): *The Lock In program will be in all counties of the state except the current 16 counties covered through Passport. Passport (PHP) does their own Lock-In Program and oversees their locked in population/members for the 16 counties in the greater Louisville area* *Mandatory enrollment shall be initiated for a recipient if in any two (2) 180 calendar day periods within an eighteen (18) months' timeframe.* *(a) Received services from at least five (5) different providers;* *(b) Received at least ten (10) different prescription drugs; and received prescriptions from at least three (3) or more different pharmacies; or* *(c) Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; or* *(d) Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.*

Citation	Condition or Requirement

i. county/counties (mandatory) _____

ii. county/counties (voluntary)_____

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ___ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. _X_ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met

Exception would be freedom of choice as outlined in 42CFR 431.54.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. _X_ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)

4. _X_ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as 1905(a)(4)(C) defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. _X_ The state assures that all the applicable requirements 42 CFR Part 38 for MCOs and PCCMs will be met.

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ___The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. Not applicable – this is not an "at risk" contract.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. _X_The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 74.40	8. _X_The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. *Eligible groups are as identified in Section B-5 of the pre-print as over utilizing Medicaid services. Any Medicaid recipient that is at least 19 years of age or not in the Passport service area that has been found to over utilize Medicaid services will be placed in the Lock-In program.* 2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. *Not applicable – no voluntary enrollment*

Citation	Condition or Requirement
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ____Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients, who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ____Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
	E. Identification of Mandatory Exempt Groups *Children, under the age of 19 years of age are exempt from the Lock-In Program*
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* *Children, under the age of 19 years of age are exempt from the Lock-In Program*

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: *Not applicable because no one under the age of 19 will be enrolled into the Lock – In* ____i. program participation, ____ii. special health care needs, or ____iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. *Not applicable because no one under the age of 19 will be enrolled into the Lock – In* ____i. yes ____ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* *Children, under the age of 19 years of age are exempt from the Lock-In Program. Children will be identified through age edits in the MMIS system. This response is applicable to item i. – iv. Below.* i. Children under 19 years of age who are eligible for SSI under title XVI; ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; iii. Children under 19 years of age who are in foster care or other out-of-home placement; iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Citation		Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	5.	Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* *All children under 19 years of age are exempt from the Lock-In Program.*
1932(a)(2) 42 CFR 438.50(d)	6.	Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. *Medicare recipients are exempt from the Lock-In Program and will be identified through MMIS edits.* ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. *Not applicable – Kentucky does not have Indian Tribes*
42 CFR 438.50	F.	List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment *Nursing facility patients that have been in the nursing home or long-term care facility for more that 30 days in a given calendar year are exempt*
42 CFR 438.50	G.	List all other eligible groups who will be permitted to enroll on a voluntary basis *Not applicable.*

Citation	Condition or Requirement

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

If the recipient's provider has agreed to be a Lock In provider, the recipient will be allowed to continue treatment with the existing provider.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

If the recipient's provider has agreed to be a Lock In provider, the recipient will be allowed to continue treatment with the existing provider.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will __X__/will not ____ use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Lock-In recipients will receive a letter from the KY Department for Medicaid Services informing them that they are being placed in the Lock-In Program. The letter will outline the reason they are being placed in the Program, and allowing them 30 days to select their Primary Care Physician (PCP) or narcotic provider or one will be assigned for them. Medicaid recipients shall have a choice from at least two (2) participating providers in their area

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Not applicable under authority of 42 CFR 431.54

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program

Citation	Condition or Requirement

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

Not applicable for this program under authority of 42 CFR 431.54

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

   Except as outlined in 42 CFR 431.54

3. _X_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _____ This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

Citation		Condition or Requirement

5. _X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _X_/will not___ use lock-in for managed care.

2. The lock-in will apply for _24_ months (up to 24 months).

*We initially lock the member in for **24 months** but at 12 months intervals, member utilization reviews are conducted. (Any subsequent lock in period is for 12 months at a time)*

Per authority of 42 CFR 431.54

3. Place a check mark to affirm state compliance.

_X_The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

The state does not allow disenrollment without cause.

4. Describe any additional circumstances of "cause" for disenrollment (if any).

Recipient or provider may request to disenroll from the Lock In program if:

(a) the designated provider submits to the department a written request for a release from serving as the recipient's designated provider. The provider shall continue to serve as the recipient's designated provider until a comparable designated provider is selected;

(b) The recipient relocates outside of the designated provider's geographic area;

Citation	Condition or Requirement

(c) The recipient submits a written request to the department which:
   1. Requests a designated provider change; and
   2. Includes information to support cause or a necessary reason for the change, including the recipient:

(d) Was denied access to a needed medical service;

(e) Received poor quality of care; or

(f) Does not have access to a provider qualified to treat the recipient's health care needs;

(g) The designated provider withdraws or is terminated from participation in the Medicaid Program; or

(h) The department determines that it is in the best interest of the lock-in recipient to change the designated provider.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Citation		Condition or Requirement
1932 (a)(1)(A)(ii)	M.	Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

Not applicable

1. The state will_____/will not __X___ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. __X__ The selective contracting provision in not applicable to this state plan.